Reset

Medical Request

M Q 0 3

DO NOT USE THIS SPACE

CHECK BOX IF THIS REQUEST ADDS MEDICAL ISSUES TO A PENDING MEDICAL REQUEST ☐

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

NOTE: Before filing this form, call the workers' compensation insurer. If that does not resolve the issue, call Workers' Compensation Benefit Management and Resolution at (651) 284-5032 (or 1-800-342-5354).

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	PHONE # (include area code)

EMPLOYEE ADDRESS	INSURER/SELF-INSURER/TPA
CITY STATE ZIP CODE	INSURER ADDRESS
EMPLOYER NAME	CITY STATE ZIP CODE
EMPLOYER ADDRESS	CLAIM REPRESENTATIVE NAME
CITY STATE ZIP CODE	INSURER CLAIM # / INSURER PHONE # / EXT

INSTRUCTIONS:

- This form must be filled out **completely**; otherwise, it may be **returned** to you.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- This form may not be used to request wage loss, vocational rehabilitation, or permanent partial disability benefits.

I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION.
For more information, call the Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354. ☐ **YES** ☐ **NO**

1. **THIS REQUEST IS BEING COMPLETED BY:**

☐ Employee ☐ Employee's Attorney ☐ Employer ☐ Insurer/TPA Self-insured ☐ Insurer's Attorney ☐ Health Care Provider

2. **Are medical services being provided or managed by a certified managed care plan?** ☐ **YES** ☐ **NO** If yes, attach information showing that the dispute resolution process of the certified managed care plan has already been exhausted.

3. **MEDICAL ISSUES (check only those that apply)**
I request:

☐ a. that health care provider bills be paid. (List all health care providers whose bills or services are in dispute. Attach extra sheets if needed. Itemized bills and supporting medical reports must be attached.)

NAME	ADDRESS	UNPAID BALANCE

☐ b. a change of treating doctor:

FROM:	NAME	ADDRESS	SPECIALTY
TO:	NAME	ADDRESS	SPECIALTY

☐ c. that prescribed treatment, surgery or equipment be provided. (Specify the requested surgery or equipment & attach supporting medical reports.) _____

☐ d. that the employee's medical expenses be reimbursed (e.g., mileage, prescription drugs). Attach supporting medical reports.

☐ e. a second opinion or consultation with

NAME	SPECIALTY

☐ f. other (explain):

IF YOU DO NOT COMPLETE SECTION 4 ENTIRELY, WE WILL NOT BE ABLE TO PROCESS YOUR REQUEST.

4. HAS ANYONE OTHER THAN THE WORKERS' COMPENSATION INSURER PAID HEALTH CARE PROVIDER BILLS RELATED TO THIS DISPUTE? ☐ YES ☐ NO

If yes, bills were paid by: ☐ employee ☐ Veterans Administration ☐ Dept. of Human Services (Welfare)
☐ Medicare ☐ Social Security Administration ☐ private health insurance ☐ other

In the space below, provide the name(s) of the person(s) or organization(s) checked above. Attach extra sheets if necessary.

NAME	ADDRESS	POLICY NUMBER

5. Explain the details of your request. Attach all documents, such as medical reports and bills, and also identify any applicable treatment parameter or other rule that support(s) your request. A decision may be based solely on these documents, the Workers' Compensation Division file, and the response to this form.

6. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, health care provider, attorneys, and any party named in #4 above who has paid medical expenses. Provide the names and addresses below. Attach extra sheets if necessary.

NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE

I sent a copy of this form and all attachments to the parties listed in #6 on _____ (date)

PRINT NAME OF PERSON FILING THIS REQUEST			SIGNATURE		
ADDRESS			ATTORNEY REGISTRATION #		
CITY	STATE	ZIP CODE	PHONE # (include area code)	EXT	DATE SIGNED

WHEN YOU HAVE FULLY COMPLETED THIS FORM, SEND IT AND ALL ATTACHMENTS TO:

Benefit Management and Resolution Unit
Workers' Compensation Division
Department of Labor and Industry
PO Box 64218
St. Paul, MN 55164-0218

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.